

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2012
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5215 HOLY CROSS PKWY MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00108722 Unsubstantiated: No deficiencies cited.</p> <p>Date: 9/24/12</p> <p>Facility Number: 005012</p> <p>Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor</p> <p>Saint Joseph Regional Medical Center is in compliance with 410 IAC 15-1.6-2, Emergency services, and 410 IAC 15-1.5-9, Radiologic services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 10/10/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

HDU711

If continuation sheet 1 of 1